MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12118 12093

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Pasadena, Md.
d. STREET ADDRESS: Bayside Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anne E (Anne) — Middle: A. — Last: ADAMS

4. DATE OF DEATH: Month: November — Day: 28 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew B. Sheridan

14. MOTHER'S MAIDEN NAME: Rose Anne Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): -- ---

16. SOCIAL SECURITY NO.: 579-28-2773

17. INFORMANT: Mrs. L. V. Itzoe, New Freedom, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastasis to lung of — INTERVAL BETWEEN ONSET AND DEATH: 1 mon.
DUE TO (b): Carcinoma of breast — 2 yrs.
DUE TO (c): —

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~this hospital~~ attended the deceased from Nov. 16, 1960 to Nov. 28, 1960, that (I) ~~(we)~~ last saw the deceased alive on Nov. 28, 1960, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/28/60

22c. PHYSICIAN'S NAME (Type): Frank M. Shipley

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 1, 1960

23c. NAME OF CEMETERY OR CREMATORY: St. John R. C. Cem.

23d. LOCATION (City, town, or county) (State): New Freedom, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Jacob Kartenstein, New Freedom, Pa.

25a. REC'D BY REGISTRAR DATE: DEC 2 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If additional time is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages, 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12094

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 30 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel Race Track

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: Cape May County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: 941 Bay Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67X-3

3. NAME OF DECEASED (Type or print): First: Avis — Middle: G. — Last: Allen

4. DATE OF DEATH: Month: Nov.11th. — Day — Year: 1960

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/10/99

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Leesburg, N.J.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Abel

14. MOTHER'S MAIDEN NAME: Abbie Chance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mr. Walter J.Allen — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion & — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11/11/60

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

Address (Street, city, town, or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 16, 1960

22c. NAME OF CEMETERY OR CREMATORY: Leesburg Methodist

22d. LOCATION (City, town, or country): Leesburg (State): New Jersey

23. FUNERAL DIRECTOR: Ide Witt Donaldson — ADDRESS: Laurel, Maryland

24a. REC'D BY REGISTRAR: DATE NOV 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

CERTIFICATE OF DEATH

12095

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 33 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: District Training School Children's Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 470 - N Street S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: ; Last: Anderson

4. DATE OF DEATH: Month: November; Day: 20; Year: 1960

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1885

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Anderson

14. MOTHER'S MAIDEN NAME: Alice Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

INFORMANT: Children's Center, Laurel, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia
DUE TO (b): Senility
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental retardation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1957, to Nov. 20, 1960, that I last saw the deceased alive on Nov. 20, 1960, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Boyland M.D.
ADDRESS (Street, city or town, state): Children's Center, Laurel, Md.
DATE SIGNED: 11/21/60

PHYSICIAN'S NAME (Type): James E. Boyland
Children's Center, Laurel, Md. 11/21/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-22-60
22c. NAME OF CEMETERY OR CREMATORY: Congressional
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Fillmore Lees
ADDRESS: 500 F St NE Wash. D.C.

24a. REC'D BY REGISTRAR (DATE): NOV 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1219

12096

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Harwood
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle Hudson — Last ARMIGER

4. DATE OF DEATH: Month November — Day 9 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours 5 — Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Kenneth ARMIGER

14. MOTHER'S MAIDEN NAME: Ruth Estelle PRENDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGENITAL HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
754.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PREMATURITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this physician~~) attended the deceased from Nov. 8, 1960, to Nov. 9, 1960, that (I) (We) last saw the deceased alive on Nov. 9, 1960, and that death occurred at 1:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart H. Walker M.D. — 22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Stuart H. Walker

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 11, 1960

23c. NAME OF CEMETERY OR CREMATORY: Woodfield

23d. LOCATION (City, town, or county) (State): Gaithersville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty — ADDRESS: Gaithersville Md.

25a. REC'D BY REGISTRAR DATE NOV 21 '60

25b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

20632 13 X U 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12120

12097

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 19 Cathedral Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 19 Cathedral Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNARD F Middle BASIL Last

4. DATE OF DEATH: Month NOVEMBER Day 5, Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1885

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Maryland Governors Office

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fletcher Basil

14. MOTHER'S MAIDEN NAME: Elizabeth Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 214 05 1767

17. INFORMANT: Mrs Nellie I. Basil- Wife- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate Gland with
DUE TO (b): metastasis to Spine
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

177X

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 19 60 to 11-5- 19 60 that I last saw the deceased alive on 11-5- 19 60, and that death occurred at 4.00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James Martin M.D.
ADDRESS (Street, city or town, state): 6 Shaw Street, Annapolis, Md.
DATE SIGNED: 11-7-60

PHYSICIAN'S NAME (Type): James Martin MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 8, 1960

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12998

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AIEME PM 7/59

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 118 O'Berry Court

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 118 O'Berry Court
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: KYLE — Middle: ROBBIE — Last: BELT

4. DATE OF DEATH: Month: November — Day: 24 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 2-60

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 1 — Days: 22 Days — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ********** — 10b. KIND OF BUSINESS OR INDUSTRY: **********

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Belt

14. MOTHER'S MAIDEN NAME: Lillian Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: George W. Belt- 118 Obery Court-Anna.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial pneumonitis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: W. Bradley King, Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county):

DATE SIGNED: 11/25/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-26-60 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill — 22d. LOCATION (City, town, or country): Annapolis, Md. (State)

23. FUNERAL DIRECTOR: C.E.Hicks III — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR: DA DEC 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12122

CERTIFICATE OF DEATH

12093

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b: 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena (Lake Shore)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. Co. Gen'l - Hospital	d. STREET ADDRESS: Rt. 10 - Box 358 (Wiggins Rd) — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Leonard	Middle: Louis	Last: Bender	4. DATE OF DEATH	Month: NOV.	Day: 16	Year: 1960

5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: [redacted]	9. AGE (In years last birthday): 59 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian (Ret.)	10b. KIND OF BUSINESS OR INDUSTRY: Alleg. Gd-if Educ.	11. BIRTHPLACE (State or foreign country): Fort Wayne Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Bender	14. MOTHER'S MAIDEN NAME: Sophia Hannick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): '24 - '27	16. SOCIAL SECURITY NO.: 218-10-4801	17. INFORMANT: Mrs. Philomena Bender	Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	TERMINAL BRONCHO-PNEUMONIA	24 HRS.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)	MASSIVE CEREBRAL HEMMORHAGE	72 HRS
DUE TO (c)	HYPERTENSIVE CARDIOVASCULAR DISEASE	4 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from AUGUST, 1956, to NOV. 15, 1960, that I last saw the deceased alive on NOV 15, 1960, and that death occurred at 12.40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): 2934 MOUNTAIN RD. — DATE SIGNED: 11-16-60

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR. — PASADENA, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 19th Nov. 1960	22c. NAME OF CEMETERY OR CREMATORY: Glen Haven	22d. LOCATION (City, town, or county): Glen Burnie	(State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Singleton	ADDRESS: Glen Burnie, Md.	24a. REC'D BY REGISTRAR DATE: NOV 21 '60	24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12123

12100

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 608 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: E — Last: Bennett

4. DATE OF DEATH: Month: 11 — Day: 2 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-29-1920

9. AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert F. Revell

14. MOTHER'S MAIDEN NAME: Mabel H. Starr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Thomas E. Bennett — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous cell carcinoma, metastatic, left groin — INTERVAL BETWEEN ONSET AND DEATH: 5 mo.
DUE TO (b): Squamous cell carcinoma, left mid-toe.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 24 1960 to Nov. 2 1960 that (I) (we) last saw the deceased alive on Nov. 2 1960, and that death occurred at 9:45 PM from the causes and on the date stated above

22a. SIGNATURE: Francis I. Codd M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-2-60

22c. PHYSICIAN'S NAME (Type): Francis I. Codd

22d. ADDRESS: Severna Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-5-60

23c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel

23d. LOCATION (City, town, or county) (State): Annapolis Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: NOV 7 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12124

CERTIFICATE OF DEATH

12101

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Tracys Landing
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Meda — Middle S. — Last BINGHAM

4. DATE OF DEATH: Month November — Day 15 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25, 1882

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lewis Wm Spies

14. MOTHER'S MAIDEN NAME: Bella Below

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Colonel K. Bingham — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost
(b): Myocardial & renal insufficiency
DUE TO
(c): Generalized arteriosclerosis with hypertension

422.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (the coroner) attended the deceased from Oct. 16, 1960, to Nov. 15, 1960, that (I) (we) last saw the deceased alive on Nov. 15, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

22a SIGNATURE: Emily H. Wilson M D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 11/16/60

22c PHYSICIAN'S NAME (Type): Emily H. Wilson

22d ADDRESS: Lothian, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-18-1960

23c NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

23d LOCATION (City, town, or county): Roanoke (State): Va.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: NOV 21 '60

25b REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12161

12102

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5317 Ritchie Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Baltimore 25
d. STREET ADDRESS: 5317 Ritchie Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Angeline; Middle: Lena; Last: Bohlman

4. DATE OF DEATH: Month: Nov.; Day: 30; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 Aug., 1885

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Miexner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-01-6665B

17. [redacted] Address: Herman Bohlman, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis, Gastric. — INTERVAL BETWEEN ONSET AND DEATH: 11 mos.

175.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to November, 1960, that (I) (we) last saw the deceased alive on 11-25, 19[illegible], and that death occurred at [illegible] M. from the causes and on the date stated above.

22a. SIGNATURE: C. R. MacDonald M.D. M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 12-2-60

22c. PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.

22d. ADDRESS: 204 Crain Hghy. SW, Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3 Dec., 1960

23c. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer

23d. LOCATION (City, town, or county) (State): Baltimore City, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley

ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: DEC 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12162 12103

CERTIFICATE OF DEATH

Items 8 & 9, Film G0276 12/15/60.eac.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 211 Kent Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admiss'on)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 211 Kent Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Alexander Middle J. Last Brown
4. DATE OF DEATH: Month 11 Day 14 Year 19 60

5 SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-12-1886
9 AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman
10b KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Brown
14. MOTHER'S MAIDEN NAME: Mary Norris

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ___
16 SOCIAL SECURITY NO: 212 07 [illegible]
17 INFORMANT: Mrs. Ethel K. Brown Address: 211 Kent Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c): Arteriosclerosis

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19 ___
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 9 19 60 to Nov 18 19 60 that (I) (we) last saw the deceased alive on Nov 5 1960 and that death occurred at 1 PM, from the causes and on the date stated above.

22a SIGNATURE: Joseph Taler, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Nov 19, 60
22c. PHYSICIAN'S NAME (Type): JOSEPH TALER
22d. ADDRESS: 1028 A Block N.E. Glen Burnie Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-22-60
23c NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
23d LOCATION (City, town, or county) (State): Glen Burnie Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. Stevens Funeral Home, Inc.
ADDRESS: 1501 E. Pratt Balto
25a. REC'D BY REGISTRAR DATE: NOV 21 '60
25b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be assumed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12104

CERTIFICATE OF DEATH

12163

Reg.-Dist. No. 23 -

1 PLACE OF DEATH
a. COUNTY: Anne Arundel Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 20 yrs

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 404 Delma Av. Glen Burnie Md
d. STREET ADDRESS: 404 Delma Av.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Charles Middle Carl Last Burkowske.

4. DATE OF DEATH: Month November Day 24. Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1867
9 AGE (In years last birthday) 93 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer for B & O. R.R.
10b. KIND OF BUSINESS OR INDUSTRY: Labor
11. BIRTHPLACE (State or foreign country): Germany.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Adam Burkowske
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Mrs. M. M. Hunt. Address: 404 Delma Av. Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b): Acute Influenza — 10 days
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f (City or town) — (County) — (State) —

21. I certify that I attended the deceased from Nov 1, 1960, to Nov 24, 1960, that I last saw the deceased alive on Nov 24, 1960, and that death occurred at 11:07 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James S. Billingsley M.D. ADDRESS (Street, city or town, state): 114 Century Av. Glen Burnie Md DATE SIGNED: Nov 27. 60

PHYSICIAN'S NAME (Type): James S Billingsley M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 28-NOV. 1960
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county): Baltimore City (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R V Leigh ADDRESS: Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE: DEC 5 '60
24b. REGISTRAR'S SIGNATURE: Caroline E Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12125

CERTIFICATE OF DEATH

12106

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 109 Ralph Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle; Middle: Reed; Last: BURRELL

4. DATE OF DEATH: Month: November; Day: 29; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 23, 1881

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Reed

14. MOTHER'S MAIDEN NAME: Julia Muzzy

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 222-09-8487

17. INFORMANT: Donald W. Burrell — Address: 521 Meadow Lane, Falls Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of bladder - terminal — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Nov. 19, 1960 to Nov. 29, 1960 that (I) (~~He~~) lost saw the deceased alive on Nov. 29, 1960, and that death occurred at 1:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Jesse L. Wilkins, M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/29/60

22c. PHYSICIAN'S NAME (Type): Jesse L. Wilkins

22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-1-60

23c. NAME OF CEMETERY OR CREMATORY: Gracelawn Mem. Pk.

23d. LOCATION (City, town, or county) (State): Farnhurst, Delaware

24. FUNERAL DIRECTOR'S SIGNATURE: William J Warwick
ADDRESS: Newark, Dela.

25a. REC'D BY REGISTRAR DATE: DEC 1 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Price

WILLIAM J. WARWICK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12164

CERTIFICATE OF DEATH

12107

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9 years 5mo. 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomco
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ] Rural

3. NAME OF DECEASED (Type or print): First: Louis; Middle: Anthony; Last: Burton

4. DATE OF DEATH: Month: 11; Day: 18; Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 5, 1901

9. AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): TBc of Lungs
DUE TO
(c): Central Nervous System Syphilis, General Paresis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year, Hour o'clock, p. m.: ---------- 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): ----------

21. I certify that (I) (this hospital) attended the deceased from 6/7 1951 to 11/18 1960, that (I) (we) last saw the deceased alive on 11/18 1960, and that death occurred at 8:25 P. M. from the causes and on the date stated above

22a. SIGNATURE: Hildegard Heard Reissman M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 11/21/60
22c. PHYS CLERK'S NAME (Type): Hildegard Heard Reissman, M. D.
22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11/25/1960
23c. NAME OF CEMETERY OR CREMATORY: Quantico
23d. LOCATION (City, town, or county) (State): Quantico Md

24. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart
ADDRESS: Salisbury Md.
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, deliver the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12126

12108

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HOMEWOOD NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRO GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md 1671
d. STREET ADDRESS: 4506 - College Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELOISE Middle PETRIE Last CLAFLIN

4. DATE OF DEATH: Month 11 Day 7 Year 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: aug 5 - 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederick O. Petrie
14. MOTHER'S MAIDEN NAME: Nora Moeller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Louis Mendel Address: College Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL ARTERY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 WK.
DUE TO
332 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1957 to 4/7 1960, that (I) (we) last saw the deceased alive on 11/6 1960 and that death occurred at 2:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard N Peeler M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Nov 7 '60
22c. PHYSICIAN'S NAME (Type): RICHARD N. PEELER
22d. ADDRESS: ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Nov 10, 1960
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Crematory
23d. LOCATION (City, town, or county) (State): Colmar Manor Md

24. FUNERAL DIRECTOR'S SIGNATURE: T Basil Sons ADDRESS: Hyattsville Md
25a. REC'D BY REGISTRAR DATE: NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
15M 9/5

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12165

13328

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: –
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hanover
d. STREET ADDRESS: 1 Tall Pines Trailer Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BRUCE Middle TED Last COLLINS JR.

4. DATE OF DEATH: Month November Day 30 Year 19 60

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ N/A DIVORCED ☐

8. DATE OF BIRTH: 30 Nov 60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months – Days –
IF UNDER 24 HRS: Hours 5 Min. 52

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): –

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: –

13 FATHER'S NAME: Bruce T. Collins

14. MOTHER'S MAIDEN NAME: Jackie Latture

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) – If yes, give war or dates of service: –

16. SOCIAL SECURITY NO.: –

17. INFORMANT Address: Medical Records USA Hosp Ft G G Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 30 Nov 1960 to 30 Nov 1960, that (I) (we) last saw the deceased alive on 30 Nov 1960, and that death occurred at 1615 M, from the causes and on the date stated above.

22a SIGNATURE: Herman S Robinson Capt MC M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 30 Nov 60

22c. PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON, Capt., M.C.

22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12/3/60

23c. NAME OF CEMETERY OR CREMATORY: Ivandale Cemetery

23d LOCATION (City, town, or county) (State): Benhams Virginia

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: DeWitt Donaldson, Laurel, Md

25a. REC'D BY REGISTRAR DATE: DEC 9 '60

25b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12127 Item 7 Feb 1964 Letter OK

12109

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 2 Southgate AVe.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Katharine; Last: COX

4. DATE OF DEATH: Month: November; Day: 6; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 17, 1895

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jerome A Cox

14. MOTHER'S MAIDEN NAME: Lillian Rockhold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Jerome Cox — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO (b): Arteriosclerotic Heart Disease — 5 YRS

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~this decedent~~ attended the deceased from 5 Nov 1960, to Nov. 6, 1960, that (I) ~~did~~ last saw the deceased alive on Nov. 6, 1960, and that death occurred at 10:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/7/60

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-9-1960
23c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
23d. LOCATION (City, town, or county) (State): Preston Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR: DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Caroline L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12128 | 12110 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A Co. | MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 301 Burnside St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 301 Burnside St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah | Middle T. | Last Crane

4. DATE OF DEATH: Month Nov. | Day 30 | Year 1960

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 14, 1867

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas E. Maley

14. MOTHER'S MAIDEN NAME: "Unknown"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Jacob L. Crane | Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yr.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4 2 2 . 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19—, to Nov. 30, 1960, that I last saw the deceased alive on Nov. 1, 1960, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Hedeman M.D. ADDRESS (Street, city or town, state): 121 CATHEDRAL ST. ANNAPOLIS MD DATE SIGNED: 12/1/60

PHYSICIAN'S NAME (Type): JOHN J HEDEMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-5-1960

22c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

22d. LOCATION (City, town, or county) (State): Evanston, Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: DEC 5 '60

24b. REGISTRAR'S SIGNATURE: Edith L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12166

12112

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 13 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 207 Queen Ann Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss on) a. STATE: Maryland b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie,
d. STREET ADDRESS: 207 Queen Ann Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Chester Middle Last Dunkerly
4. DATE OF DEATH: Month Nov. Day 13 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 17 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouse Man
10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.
11. BIRTHPLACE (State or foreign country): Voiletville Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Dunkerly
14. MOTHER'S MAIDEN NAME: Laura Chappman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 705-09-1634
17. INFORMANT: Mr. Melvin Dunkerly Address: Hanover, Md. RFD,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cancer of Lung & Hypertension — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/21/58 19___ to 11/13 19 60, that (I) (we) last saw the deceased alive on 11/13 19 60, and that death occurred at ____ M, from the causes and on the date stated above

22a. SIGNATURE: Louis L. Ball jr. M. D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/14/60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 16 Nov. 1960
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park
23d. LOCATION (City, town, or county) (State): Howard Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE NOV 21 '60
25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12167

12113

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nina — Middle Poe — Last Elder

4. DATE OF DEATH: Month Nov. — Day 2 — Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-7-1873

9. AGE (In years last birthday): 87 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: N. Poe Neilson

14. MOTHER'S MAIDEN NAME: Alice Minis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT — Address:
Mrs. Sarah Elder Symington — Aboyne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of the left breast — INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO (b): with metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 11, 1960, to Nov. 2, 1960, that (I) (~~we~~) last saw the deceased alive on October 25 1960 and that death occurred at 9:40 AM from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Nov. 2, 1960

22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-5-60

23c. NAME OF CEMETERY OR CREMATORY: St. Johns

23d. LOCATION (City, town, or county) (State): Balto. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: H. W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto. 12, Md.

25a. REC'D BY REGISTRAR DATE NOV 4 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12129

12114

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: Carvel Hall Hotel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Janie — Middle E. — Last FELDMEYER

4. DATE OF DEATH: Month November — Day 22 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 13th 1872
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Gottlieb Feldmeyer
14. MOTHER'S MAIDEN NAME: Dorothy Obery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Edward J. McQuiston 530 E. 23rd St New York City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 18 hr.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — yrs.
DUE TO
(c) Coma from melena s/a

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Congestive failure.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from Sept. —, 1959, to Nov. 22, —, 1960, that (I) (~~he~~) last saw the deceased alive on Nov. 22, 1960, and that death occurred at 10:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/22/60
22c. PHYSICIAN'S NAME (Type): Frank M. Shipley
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 25 1960
23c. NAME OF CEMETERY OR CREMATORY: St Annes Cemt
23d. LOCATION (City, town, or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Snyder Sons
ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur L Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12130

CERTIFICATE OF DEATH

12115 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 20 Annapolis (Winchester)
d STREET ADDRESS: 5 Riverdale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Joseph Middle H. Last Fisher

4. DATE OF DEATH: Month November Day 18 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-2-1915

9. AGE (In years last birthday): 44 yrs

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Chemical

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H Fisher

14. MOTHER'S MAIDEN NAME: Elizabeth Ann Mathews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: 217-07-3796

INFORMANT: Mrs. Betty C. Fisher Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15-30 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19____, to ____, 19 60 that I last saw the deceased alive on Nov 1, 19 60, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Francis I Codd M.D. ADDRESS (Street, city or town, state): Severna Park, Maryland DATE SIGNED: 11-18-

PHYSICIAN'S NAME (Type): Francis I. Codd M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-22-60

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral

22d LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

24a REC'D BY REGISTRAR DATE: NOV 21 '60

24b. REGISTRAR'S SIGNATURE: Wilbur L. Mears

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12116

1. PLACE OF DEATH — a. COUNTY: 12131 Anne Arundel — MARYLAND
2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1½ days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Glen Burnie
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS: 1607 Furnace Branch Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: — Last: GESEK
4. DATE OF DEATH: Month: November — Day: 28 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 26, 1960
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours: 12 — Min.: 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Nelson~~ NONE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Stanley Joseph GESEK, Jr.
14. MOTHER'S MAIDEN NAME: Mary Magdeline THOMAS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Hospital records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 773.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO (c): Failure of Circulation & Respiration 1½ days

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY — Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) ~~(Coroner)~~ attended the deceased from Nov. 26, 1960 to Nov. 27, 1960, that (I) (We) last saw the deceased alive on Nov. 27, 1960, and that death occurred at 4:30 A.M. from the causes and on the date stated above

22a SIGNATURE: Clayton Norton M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 11/29/60
22c PHYSICIAN'S NAME (Type): Clayton Norton
22d ADDRESS: Medical Bldg., Severna Park, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 29-NOV. 60
23c NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
23d LOCATION (City, town, or county) (State): Glen Burnie Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Sindyfop Funeral Home — Asst. P. D'Ale — Glen Burnie - Md
ADDRESS:
25a. REC'D BY REGISTRAR — DATE: DEC 5 '60
25b. REGISTRAR'S SIGNATURE: Clifford L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

Nov

2063313 X V C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG

12132

12117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater Md
d. STREET ADDRESS: Route 1 Box 455
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Irma Middle Last Glass

4. DATE OF DEATH: Month 11 Day 26 Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Feb 13, 1882
9. AGE (In years last birthday): 79 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: L C Hoopes
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Francis Glass Jr Edgewater Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): generalized arteriosclerosis
DUE TO
(c):

332 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1959, to Nov. 26, 1960, that I last saw the deceased alive on Nov. 26, 1960, and that death occurred at 8:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Lothian, md — DATE SIGNED: 11-26-60

PHYSICIAN'S NAME (Type): Emily H Wilson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 29, 1960
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

CERTIFICATE OF DEATH

12118

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hunt Apolis
c. LENGTH OF STAY IN 3b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Udhow Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bay Ridge, MD.
d. STREET ADDRESS: 160 Riverview Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Betty — Middle: Shea — Last: Hartig

4. DATE OF DEATH: Month: 11 — Day: 8 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-21-1898

9. AGE (In years last Birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Daniel J. Shea

14. MOTHER'S MAIDEN NAME: Minnie B. Goudge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: S. Dale Scott — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gen. carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(b): carcinoma of cervix; uteri — 7 7 years

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a. m. p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1951, 19—, to 11/8/, 1960, that I last saw the deceased alive on 11/8/60, 19—, and that death occurred at 12 N.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Borssuck M.D. — ADDRESS (Street, city or town, state): Amos Garrett Blvd., — DATE SIGNED: 11/11/60

PHYSICIAN'S NAME (Type): S. Borssuck, M.D. — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-11-60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12134 — Reg. Dist. No. 12119

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1951 Drew Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1951 Drew Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Francis — Last: Haste

4. DATE OF DEATH: Month: November — Day: 24 — Year: 19 60

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20-1902

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ********

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Kimble

14. MOTHER'S MAIDEN NAME: Katie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

INFORMANT — Address: Marion Gunn - 1951 Drew St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Ca. — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
171 X
DUE TO (b): Ca. of Cervix — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11/23, 1960, to 11/24, 1960, that I last saw the deceased alive on 11/24, 1960, and that death occurred at 8 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson M.D. — ADDRESS (Street, city or town, state): 37 Calvert St., Annapolis, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Theodore H. Johnson, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-28-60
22c. NAME OF CEMETERY OR CREMATORY: U.S.National
22d. LOCATION (City, town or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C.E.Hicks III Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: DEC 5 '60
24b. REGISTRAR'S SIGNATURE: Catherine S. Hicks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1IIM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12168 12120

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE
c. LENGTH OF STAY IN 1b 2 mo, 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL, v.lle, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY T. Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Butlertown, Worton RR, Md.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HENRY Middle A. Last ASBURY
4. DATE OF DEATH Month 11 Day 6 Year 1960
5. SEX M
6. COLOR OR RACE N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2-23-1873
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY Furniture
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Henry Asbury
14. MOTHER'S MAIDEN NAME Catherine (Last name unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown
16. SOCIAL SECURITY NO unknown
17. INFORMANT Address Medical Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Dehydration — INTERVAL BETWEEN ONSET AND DEATH
023
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Syphilitic arteriosclerotic heart
DUE TO (c) Senile.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CNS associate C.N.S. Syphilis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/15/60 19__ to 11/6 19 60 that (I) (we) last saw the deceased alive on 11/6 1960, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE L. Benedict M.D
ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) L. BENEDICT
22d. ADDRESS Crownsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11-10-60
23c. NAME OF CEMETERY OR CREMATORY Chesterlawn
23d. LOCATION (City, town, or county) Chesterlawn (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE Walter R. Williams ADDRESS 322 Leland St
25a. REC'D BY REGISTRAR DATE NOV 10 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

CERTIFICATE OF DEATH

12169 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
c. LENGTH OF STAY IN 1b: 25 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2112 MARY AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
d. STREET ADDRESS: 2112 MARY AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILEY — Middle HENRY — Last HOFFMAN

4. DATE OF DEATH: Month NOV. — Day 16 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/12/88

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: STREET CAR

11. BIRTHPLACE (State or foreign country): BALTO., MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILEY H. HOFFMAN

14. MOTHER'S MAIDEN NAME: LAURA STEVENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 213-10-2510

17. INFORMANT: MRS. MOLLY HOFFMAN — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO (b): ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — 5 YEARS
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from NOV. 1, 1960, to NOV 16, 1960, that I last saw the deceased alive on NOV. 11, 1960, and that death occurred at 2:12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): 8421 Ft. Smallwood Rd. — DATE SIGNED: 11/16/60

PHYSICIAN'S NAME (Type): J. BRADY SMITH — PASADENA, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-19-60

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.

22d. LOCATION (City, town or county) (State): Glen Dale

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCeney-13a E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: NOV 17 '60

24b. REGISTRAR'S SIGNATURE: Caitlin L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12135

12122

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Barbara — Middle: Eileen — Last: Ingersoll

4. DATE OF DEATH: Month: Nov. — Day: 11 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1960

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert W. Ingersoll

14. MOTHER'S MAIDEN NAME: Charlotte Marie Chaney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Robert Ingersoll — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 776X — Prematurity
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 9 Nov 19 60 to 11 Nov 19 60, that (I) (we) last saw the deceased alive on 11 Nov 19 60, and that death occurred at 9:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 12 Nov 60

22c. PHYSICIAN'S NAME (Type): Dr. Stuart Walker

22d. ADDRESS: 121 Cathedral St, Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12 Nov. 1960

23c. NAME OF CEMETERY OR CREMATORY: Bethany Church Cem.

23d. LOCATION (City, town, or county) (State): Odenton Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 16 60

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12170

12123

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 year 2mo. 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2531 E. Hoffman Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Geter — Last: Jackson

4. DATE OF DEATH: Month: 11 — Day: 19 — Year: 1960

5 SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Unknown

8 DATE OF BIRTH: August 27, 1876

9. AGE (In years last birthday): 84 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ------

11 BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17 INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Tuberculosis

DUE TO (b): Senility and Cachexia

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ----------

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: -------

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): -------

21 I certify that (I) (this hospital) attended the deceased from 9/4 1959 to 11/19 1960 that (I) (we) last saw the deceased alive on 11/19 1960 and that death occurred at 7:00 P.M. from the causes and on the date stated above

22a. SIGNATURE: Lionel McHenry Mapp M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 11/21/60

22c. PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22d ADDRESS: Crownsville State Hospital, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 11/28/60

23c ~~NAME OF CEMETERY OR CREMATORY~~: University of Maryland

23d. LOCATION (City, town, or county) (State): Balt., Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Reese Ann. Md.

25a. REC'D BY REGISTRAR — DATE: NOV 29 '60

25b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12124

1. PLACE OF DEATH
a. COUNTY: A.A.Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S.N.-Anne Arundel. General.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: WASH. D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 600 CONDON TERRACE, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Joseph	D.	JAMISON	11	8	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	C		MARCH 3 1914	46 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED	—	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES		THERESA JAMISON	600 CONDON TERR. S.E. WASHINGTON D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Fracture Skull	Instant
812X DUE TO (b)	Extreme Cerebral Injury	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
	Auto accident - Route 2 - Pedestrian				
20c. TIME OF INJURY Hour a.m. (p.m.)	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town,	(County,	(State)
	11-8 1960		Highway.		A.A.Co.	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E Linhardt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) E Linhardt

Address (Street, city, town, or county)

DATE SIGNED 11. 8. 60.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
BURIAL	11-15-60	ARLINGTON NAT.	ARLINGTON	VIRGINIA

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W. ERNEST JARVIS CO.	1432 YOU ST. N.W.	NOV 14 '60	Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12171

CERTIFICATE OF DEATH

12125

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Solomons
d. STREET ADDRESS: Hwy 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANDREW Middle W Last JOHNSON

4. DATE OF DEATH: Month Nov. Day 27 Year 1960

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 27 1872

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tobacco Inspector

10b. KIND OF BUSINESS OR INDUSTRY: State Employee

11. BIRTHPLACE (State or foreign country): Isle of Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Johnson

14. MOTHER'S MAIDEN NAME: Amelia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Ethel Z. Mattingly — Address: Brooklyn Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/22 19 60 to 11/27 19 60 that I last saw the deceased alive on 11/25 19 60, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel Rubin M.D. — ADDRESS (Street, city or town, state): 203 Patapsco Ave — DATE SIGNED: 11/27/60

PHYSICIAN'S NAME (Type): SAMUEL RUBIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 29, 1960

22c. NAME OF CEMETERY OR CREMATORY: Solomons Methodist

22d. LOCATION (City, town, or county) (State): Solomons Calvert Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. A. Hasbrouck & Son — ADDRESS: Mutual, Md.

24a. REC'D BY REGISTRAR DATE: NOV 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12172

12126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 2 yr.-4 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): District Training School Children's Center

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X -
d. STREET ADDRESS: 913 - 5th Street S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Ezell; Last: Johnson

4. DATE OF DEATH: Month: November; Day: 2; Year: 1960

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/18/42

9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Newell Johnson

14. MOTHER'S MAIDEN NAME: Mary Alice Jones

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): --
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Children's Center, Laurel, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Aspiration pneumonitis (repeated episodes) — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.4mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Spastic quadriplegia

DUE TO

(c) Mental retardation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Convulsive disorder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): --

20c. TIME OF INJURY Hour: o. m. / p. m. --; Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State): --

21. I certify that I attended the deceased from June 6, 1958 to Nov. 2, 1960 that I last saw the deceased alive on Nov. 2, 1960, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Boyland M.D.
ADDRESS (Street, city or town, state): Children's Center, Laurel, Md.
DATE SIGNED: 11/2/60

PHYSICIAN'S NAME (Type): James E. Boyland, M.D.
Children's Center, Laurel, Md. 11/2/60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11/8/60

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Hoffman Funeral Home 909-6th St N.W.

24a. REC'D BY REGISTRAR DATE: NOV 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12137

CERTIFICATE OF DEATH

12127 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 104 Clay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Florence — Middle: CRAIN Hopkins — Last: Jones

4. DATE OF DEATH: Month: Nov. 16 — Day — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 14 - 1883

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ********** (redacted)

11. BIRTHPLACE (State or foreign country): A.A.Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sam Jones

14. MOTHER'S MAIDEN NAME: Isabel Hillary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Annie Thomas — Address: 104 Clay St. Annapolis-Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure due

449 7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): to Arteriosclerotic Hypertensive Cardio

DUE TO (c): Vascular disease and Grade III

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/15, 1960 to Nov. 17, 1960, that I last saw the deceased alive on Nov 17, 1960, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: R L Richardson M.D.

PHYSICIAN'S NAME (Type): R.L.Richardson M.D. — 110 Clay Street Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-19-60

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. L. Hicks Sr. — ADDRESS: Annapolis-Md.

24a. REC'D BY REGISTRAR DATE: NOV 23 '60

24b. REGISTRAR'S SIGNATURE: Thos S Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG276 12-14-60 et

12139

12128

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville (Elvaton Acres)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hospital
d. STREET ADDRESS: RFD # 1 Dogwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHRYN Middle Lost KATLIC

4. DATE OF DEATH: Month NOV. Day 10 Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 17 July 1910
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Louisville Ky.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: (unknown) Lacefield
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: 213-28-2148
INFORMANT: Mr. Charles Katlic
Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO (b): Rheumatic heart Disease

DUE TO (c): with mutral stenosis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

410 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 4, 1960, to Nov. 10, 1960, that I last saw the deceased alive on Nov. 10, 1960, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmond I Mousabek M.D.
ADDRESS (Street, city or town, state): 2101 S. Ritchie Highway
DATE SIGNED: 11/10/60

PHYSICIAN'S NAME (Type): EDMOND I. MOUSHABEK Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 15th Nov. 1960
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City town, or county) (State): Glen Burnie, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Richard J. Singleton
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

CERTIFICATE OF DEATH

12129

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 6 Alder Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: KENNEDY

4. DATE OF DEATH: Month: 11-27 — Day — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-26-60
9. AGE (In years last birthday): — — yrs
IF UNDER 1 YEAR: Months: 0 — Days: 0
IF UNDER 24 HRS: Hours: 23 — Min.: 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — — — — — — — — — —
10b. KIND OF BUSINESS OR INDUSTRY: — — — — — — — — — —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Robert KENNEDY
14. MOTHER'S MAIDEN NAME: Marion Bernice WOISKONT

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): — — — —
16. SOCIAL SECURITY NO.: — — — — — —
17. INFORMANT — Address: (F) John Robert KENNEDY, 6 Alder Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: — — — — —

527.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8:20 Pm 11-26-60 to 8:10 PM 11-27-60, that I last saw the deceased alive on 11-27-60, 19—, and that death occurred at 8:10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John McCann M.D — ADDRESS (Street, city or town, state): — DATE SIGNED: 11-28-60

PHYSICIAN'S NAME (Type): J. J. MC CANN, LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-29-1960
22c. NAME OF CEMETERY OR CREMATORY: Naval Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Gaylen & Son — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1217 — 12130

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastern
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rte 5 Box 422 A

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): A Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mervine — Middle: — Last: Kess

4. DATE OF DEATH: Month: November — Day: 24th. — Year: 1960

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 0/5/[illegible] — 9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 2, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wdc — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond Kess — 14. MOTHER'S MAIDEN NAME: Evelynn Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Evelyn Kane (Sister) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Infection
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faulenbach M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/24/960

EXAMINER'S NAME (Type): Gustav[illegible] Hubert[illegible]
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11/26/60 — 22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Church — 22d. LOCATION (City, town, or country) (State): Magothy - Md

23. FUNERAL DIRECTOR — ADDRESS: Marion P. Hayes 638 N. Fremont St Baltimore Md

24a. REC'D BY REGISTRAR DATE: NOV 28 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

9 V V V V V X V V

[illegible] 18/12/40 [illegible] - [illegible]
[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12174 — 12131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 27
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3325 Hollins Ferry Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Baltimore 27
d. STREET ADDRESS: 3325 Hollins Ferry Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]
4. DATE OF DEATH: Month 11 Day 28 Year 60 19

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 8-18-82
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Walter Sykes.
14. MOTHER'S MAIDEN NAME: Smith ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Family — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pa-dgets Desease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 16, 1955 to NOV 28, 1960 that I last saw the deceased alive on NOV 27, 1960, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Schmfeld M.D. — ADDRESS (Street, city or town, state): 2301 Annapolis Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): PAUL Schmfeld Baltimore Md. — 11/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 12/1/60
22c. NAME OF CEMETERY OR CREMATORY: [illegible]
22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE NOV 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Tirard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

12140

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12132

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Annapolis
d. STREET ADDRESS: 1 Annapolis Roads
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joanna — Middle: Mary — Last: KNIPP

4. DATE OF DEATH: Month: November — Day: 10 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 4 — Min: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Stephen Shepard KNIPP

14. MOTHER'S MAIDEN NAME: Marion Elizabeth HAZEBROEK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Diaphragmatic Hernia left - Congenital

560.4

DUE TO (b): Hypoplasia - left lung - congenital

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from Nov. 9, 1960 to Nov. 9, 1960, that (I) saw the deceased alive on Nov. 9, 1960, and that death occurred at 1:40 A.M. from the causes and on the date stated above

22a. SIGNATURE: Philip Briscoe M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11/11/60

22c. PHYSICIAN'S NAME (Type): Philip Briscoe

22d. ADDRESS: 95 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov 12-1960

23c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem't

23d. LOCATION (City, town, or county) (State): Annapolis Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: NOV 14 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 11/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12175

CERTIFICATE OF DEATH

12133

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD
c. LENGTH OF STAY IN 1b: 2 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BUENA VISTA AVE, ARNOLD

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md.
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ARNOLD
d. STREET ADDRESS: BUENA VISTA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle S. — Last LAWRENCE

4. DATE OF DEATH: Month 11 — Day 8 — Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 5, 1877

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Derrenberger

14. MOTHER'S MAIDEN NAME: Anna Herbst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. John C. Derrenberger, Address: BUENA VISTA AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 4 hour
DUE TO
(b): CONGESTIVE HEART FAILURE — 5 YEARS
DUE TO
(c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 20 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1 1960 to 11-8 1960 that I last saw the deceased alive on 11-8 1960, and that death occurred at 8:A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. D. Yun, M.D. — ADDRESS (Street, city or town, state): RITCHIE HIGHWAY — DATE SIGNED

PHYSICIAN'S NAME (Type): J. D. YUN — SEVERNA PARK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/11/60

22c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tschan — ADDRESS: Balto. 17, Md.

24a. REC'D BY REGISTRAR DATE: NOV 9 '60

24b REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12141

12134

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Rt. 2, Box 26
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leo — Middle: E. — Last: LeBel

4. DATE OF DEATH: Month: November — Day: 18 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 May 1892

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Post Ord. FT. Meade

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W W 11

16. SOCIAL SECURITY NO.: 225-22-4017

17. INFORMANT: Mrs. Omer Butler — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Bleeding oesophageal varicen — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b): Cirrhosis of Liver — ?
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5+1.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-16 19 60 to 11-18 19 60, that (I) (we) last saw the deceased alive on 11-18 19 60, and that death occurred at 5P M, from the causes and on the date stated above

22a. SIGNATURE: Frank M Shipley M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/19/60

22c. PHYSICIAN'S NAME (Type): Frank M Shipley

22d. ADDRESS: Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-22-60

23c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l Cemetery

23d. LOCATION (City, town, or county) (State): Baltimore City Md.

24a. FUNERAL DIRECTOR'S SIGNATURE: Stapleton Funeral Home — Robert P. Ware

ADDRESS: Glen Burnie, Md

25a. REC'D BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1217 — 13219

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Riva
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Riva

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Edgewater
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First W. Middle Last KENNETH LEE
4. DATE OF DEATH: Month November Day 27 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Oct 25 1922
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE REPAIRMAN
10b. KIND OF BUSINESS OR INDUSTRY: TELEPHONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: STEPHEN LEE
14. MOTHER'S MAIDEN NAME: JULIA MEADE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give wars or dates of service) WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOSEPH LEE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Traumatic Injuries
866X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Airplane Crash
20c. TIME OF INJURY: Hour 1:00 Am Month, Day, Year Nov. 27 1960
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): field
20f. (City or town) Riva (County) Anne Arundel (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Charles S. Petty
Address (Street, city, town, or county):
DATE SIGNED: 11/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-30-1960
22c. NAME OF CEMETERY OR CREMATORY: US NATIONAL CEM
22d. LOCATION (City, town, or country): ANNAPOLIS (State) MD

23. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS — ADDRESS: ANNAPOLIS MD
24a. REC'D BY REGISTRAR DATE: NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12135

12142

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 711 Arundel Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: R. — Last: LEE

4. DATE OF DEATH: Month: November — Day: 6 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 5, 1893

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Violet Austen — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

DUE TO (b): Hypertensive Cardio Vascular Disease — 5 YRS

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

+ 43X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from 6 OCT 1960 to 6 NOV 1960, that (I) last saw the deceased alive on 21 OCT 1960, and that death occurred at 6:20 A.M. from the causes and on the date stated above

22a. SIGNATURE: Edward S. Beck M D

ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/7/60

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-9-1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemt

23d. LOCATION (City, town, or county) (State): Annapolis Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: NOV 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1217

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12136

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G.Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fort George G.Meade

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge 27
d. STREET ADDRESS: 13 - 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL Middle W. Last LIPSTER

4. DATE OF DEATH: Month Nov. Day 5, Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 3, 1960

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months 1 Days 2
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Fort George G.Meade Hos.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Roger A.Lipster

14. MOTHER'S MAIDEN NAME: Marilyn A.Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Roger A.Lipster, Address Alladin Trailer Village Elkridge 27,Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Interstitial Pneumonitis.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W Bradley King Jr. M.D.

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 11/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-8-60

22c. NAME OF CEMETERY OR CREMATORY: Markelie

22d. LOCATION (City, town, or county) (State): Hudson, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F.C.Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: NOV 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12178 12137

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (5) 15M 9-59

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): U.S.A.H.
   c. LENGTH OF STAY IN 1b: 5 hrs 25 Min
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fort George G. Meade, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
   d. STREET ADDRESS: 507 Main St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Kevin Middle Michael Last Lutz

4. DATE OF DEATH: Month November Day 10 Year 1960

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-19-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 5 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL J LUTZ

14. MOTHER'S MAIDEN NAME: BARBARA BROWER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Father — Address: 507 Main St Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congenit l Atalectesis in Newborn Infant — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs 25 min

763.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1o Nov 1960 to 1o Nov 1960 that (I) (we) last saw the deceased alive on 1o Nov 1960, and that death occurred at 7:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Sherman S. Robinson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 19 Nov 60

22c. PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON

22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/22/60

23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

23d. LOCATION (City, town, or county) (State): Middle Village Queens N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE: De Witt Donaldson — ADDRESS: Laurel Md

25a. REC'D BY REGISTRAR DATE: NOV 29 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

Hans. 205022 2XV4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12138

12143

CERTIFICATE OF DEATH

Items 6 & 9, Film G-278 1/11/61.enc

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived — If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 46 Murray Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: B — Last: MACE

4. DATE OF DEATH: Month: November — Day: 30 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 11, 1883/1886

9. AGE (In years last birthday): 74 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HENRY EDLING

14. MOTHER'S MAIDEN NAME: Georgia Mattie HAHN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: GEORGE E. MACE — Address: "

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, generalized
DUE TO (b): Perforation Sigmoid Colon
DUE TO (c): Diverticulosis Sigmoid Colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~the coroner~~) attended the deceased from Nov. 25, 1960, to Nov. 30, 1960, that (I) (~~he~~) last saw the deceased alive on Nov. 30, 1960, and that death occurred at 6:30 P.M., from the causes and on the date stated above

22a. SIGNATURE: Jesse L. Wilkins M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12/1/60

22c. PHYSICIAN'S NAME (Type): Jesse L. Wilkins M.D.

22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec 3rd 1960

23c. NAME OF CEMETERY OR CREMATORY: St Annes Cemetery

23d. LOCATION (City, town, or county): Annapolis (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Seyler Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: DEC 5 '60

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12179

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: MARYLAND; 14 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #5, Magothy Beach

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Route #5, Magothy Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY; Middle M; Last McCLAIN

4. DATE OF DEATH: Month November; Day 27; Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/13/1925

9. AGE (In years last birthday): 35 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Mr James T. McClain Address: Magothy Beach

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shotgun wound of upper abdomen and lower chest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot during altercation

20c. TIME OF INJURY: Hour 7:10 p.m.; Month, Day, Year 11/27/60

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): House

20f. (City or town) (County) (State): Pasadena, Anne Arundel, Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: R H Fisher M D

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 11/28/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/1/60

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem

22d. LOCATION (City, town, or county) (State): 5501 Frederick Ave

23. FUNERAL DIRECTOR: John J. Cowan & Son

ADDRESS: 330 Collins St.

24a. REC'D BY REGISTRAR: DATE NOV 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12180 — Reg. Dist. No. 12140

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, RFD
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Lude Drive, Lake Shore

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena, (Lake Shore)
d. STREET ADDRESS: Rt.7 - Box 24A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RAY — Middle HOWARD — Last MELLOTT

4. DATE OF DEATH: Month November — Day 5, — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X
8. DATE OF BIRTH: 2 nd. May 1903
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Self- Emp.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John G. Mellott
14. MOTHER'S MAIDEN NAME: Alice Bedford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 183 12 3953
17. INFORMANT: Mrs. Margaret Stinchcomb — Address: Kent Ave., Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): TERMINAL BRONCHO-PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS

DUE TO (b): APLASTIC ANEMIA — 3 YEARS

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 284.2, 4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CACHEXIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 22, 1960, to NOV 4, 1960, that I last saw the deceased alive on OCTOBER 25, 1960, and that death occurred at 3.55 P.M., from the couses and on the date stoted abave.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): 2934 MOUNTAIN RD. — DATE SIGNED: 11-7-60

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR. PASADENA MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8th Nov. 1960
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. D. Singleton — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR — DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12181 12141

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chaptico
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ] Rural

3. NAME OF DECEASED (Type or print): First: Ella; Middle: Counters; Last: Miles

4. DATE OF DEATH: Month: 11; Day: 3; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: January 19, 1888

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Counters

14. MOTHER'S MAIDEN NAME: Julia Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Heart Infarction
DUE TO
(b): Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: --- ---- 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that (I) (this hospital) attended the deceased from 11/3 19 58 to 11/3 19 60, that (I) (we) last saw the deceased alive on 11/3 19 60, and that death occurred at 5:30 P.M. from the causes and on the date stated above

22a. SIGNATURE: L. Benedict M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 11/4/60

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/8/60
23c. NAME OF CEMETERY OR CREMATORY: St Joseph
23d. LOCATION (City, town, or county) (State): Morganza Md.

24. FUNERAL DIRECTOR'S SIGNATURE: M. Clarke Mattingley
ADDRESS: Leonardtown Md.

25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Clifton E. Knode

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

Item 1 Film 27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12142

CERTIFICATE OF DEATH

12144 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXX Annpolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Hosp. Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Shady Side, Maryland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mae Middle A. Last Miller
4. DATE OF DEATH Month November Day 30 Year 1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	March 8- 1890	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Ohio	USA

13. FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT Address: Paul L. Miller Shady Side, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

959x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Dicumerol poisoning — same

DUE TO (c) Probably therapeutic misadventure; patient had been

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): taking dicumerol for 2 yrs. EKG. shows patient also had a recent acute myocardial infarction.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 29, 1960 to Nov. 30, 1960 that I last saw the deceased alive on Nov. 30, 1960, and that death occurred at 1725 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Willard F. Smith M.D.
ADDRESS (Street, city or town, state) Shadyside, Maryland
DATE SIGNED 11/30/60
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town or county) (State)
Burial	Dec. 3- 1960	Cedar Hill Cemetery	Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE Sinnott Brothers ADDRESS 1661- Good Hope Rd. S.E. Washington, DC
24a. REC'D BY REGISTRAR DATE DEC 2 '60
24b. REGISTRAR'S SIGNATURE Cinthia L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12182 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12143

Item 9 Film 27b 12-2 60 et

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Riva

2. USUAL RESIDENCE (Where deceased lived, If Inst tut on, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural
d. STREET ADDRESS: Woodland Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First E. Middle Last WILLIAM MILLER

4. DATE OF DEATH: Month November Day 27 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN 8, 1916

9. AGE (In years last birthday): 44 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REALTOR

10b. KIND OF BUSINESS OR INDUSTRY: REAL ESTATE

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERNEST MILLER

14. MOTHER'S MAIDEN NAME: IDA ISABELLE SWEETING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, was war or date of service) WW II

16. SOCIAL SECURITY NO.

17. INFORMANT: SHIRLEY M. MILLER #2 Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): R66X Multiple Traumatic Injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Crash

20c. TIME OF INJURY Hour a.m. 1:00 xxx Month, Day, Year Nov. 27 1960

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) field

20f. (City or town) Riva (County) Anne Arundel (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Petty

Address (Street, city, town, or county)

DATE SIGNED: 11/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-30-960

22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF CEM.

22d. LOCATION (City, town, or country) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS

ADDRESS: ANNAPOLIS MD.

24a. REC'D BY REGISTRAR DATE NOV 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12183

12144

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — STATE: MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie

c. LENGTH OF STAY IN 1b: 3 1/4 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home

d. STREET ADDRESS: 72 ½ Larkins St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Jane — Last: Mowbray

4. DATE OF DEATH: Month: November — Day: 2, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-20-1870

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Welch

14. MOTHER'S MAIDEN NAME: Catherine Tydings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17 INFORMANT Address: M. Anderson -Worker, D.P.W. A.A. Co.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. / p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 9, 1957 to Nov. 2 19 60, that (I) (~~was~~) last saw the deceased alive on Oct. 15, 19 60, and that death occurred at 8A M, from the causes and on the date stated above

22a SIGNATURE: James M. Pair M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Nov. 2, 1960

22c PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22d. ADDRESS: 400 N. Carrollton Avenue Balto. 23, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11-3-60

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

23d LOCATION (City, town, or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law — ADDRESS: Charles R. Law 802 Madison Avenue

25a. REC'D BY REGISTRAR DATE: NOV 4 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1d, Fi m 6-4 11, 1/60 EK

12184

CERTIFICATE OF DEATH

12145

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE
c LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Same Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY A.A. Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
d. STREET ADDRESS CEDAR DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HARVEY Middle F. Last MYERS Sr.
4. DATE OF DEATH Month 11 Day 8 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-1-1893
9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) V-PRES.
10b. KIND OF BUSINESS OR INDUSTRY HARDWARE Store
11 BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME HENRY B. MYERS
14. MOTHER'S MAIDEN NAME ELIZABETH HENKEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT H. FENTEN MYERS Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 wks.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3224 DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 23, 1960 to November 8, 1960 that I last saw the deceased alive on Nov 8, 1960, and that death occurred at 4:15 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE John H. Dewan M.D. ADDRESS (Street, city or town, state) 121 Cathedral St. DATE SIGNED 11/9/60
PHYSICIAN'S NAME (Type) Annapolis, Md.

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 11-11-60
22c. NAME OF CEMETERY OR CREMATORY EDWARDS CHAPEL
22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE NOV 14 '60
24b REGISTRAR'S SIGNATURE Clifford L. Powell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12145

CERTIFICATE OF DEATH

12146

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 6 hours
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Churchton
d. STREET ADDRESS: Franklin Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: LANCE Last: PHIPPS

4. DATE OF DEATH: Month: November Day: 20 Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: October 14, 1900

9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland, Churchton

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward R. Phipps

14. MOTHER'S MAIDEN NAME: Nellie Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 218030603

17. INFORMANT: ELMER R. PHIPPS Address: FRANKLIN MANOR, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443X
DUE TO (b): Cerebral arteriosclerosis & degeneration of rt. temporal and rt. occipital lobe
DUE TO (c): Hypertensive cardio-vascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: At least one year / years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac enlargement; pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from November 1 19 59 to Nov. 20, 19 60 that (I) (~~XX~~) last saw the deceased alive on Nov. 20 1960, and that death occurred at ____ M, from the causes and on the date stated above

22a. SIGNATURE: Willard F. Smith M.D
5:05 P.M.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/21/60

22c. PHYSICIAN'S NAME (Type): Willard F. SMITH

22d. ADDRESS: Shadyside, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/23/60

23c. NAME OF CEMETERY OR CREMATORY: ZION

23d. LOCATION (City, town, or county): Edgewater (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty ADDRESS: Edgewater Md

25a. REC'D BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1218.5 — 12147

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Riva
c. LENGTH OF STAY IN 1b: apprx 2½ yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Riva

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: Army Chemical Center
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle W. — Last Player
4. DATE OF DEATH: Month Nov. — Day 27 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Queen Va. 1?
9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemical Center
10b. KIND OF BUSINESS OR INDUSTRY: U.S Army
11. BIRTHPLACE (State or foreign country): Feb. 3 1935
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown - Deceased
14. MOTHER'S MAIDEN NAME: Deceased - unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): Yes Now Active
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Address: Ft. Holibird Service Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Truamatic Injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 666X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Airplane Crash
20c. TIME OF INJURY: Hour 1:00 a.m. xxxx — Month, Day, Year Nov. 27 1960
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): field
20f. (City or town): Riva — (County): Anne Arundel — (State): Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Petty — M.D.
NAME (Type): Charles S. Petty
Address (Street, city, town, or county):
DATE SIGNED: 11/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 11/30/60
22c. NAME OF CEMETERY OR CREMATORY: J.T. Morriss + Son Inc
22d. LOCATION (City, town, or country) (State): Petersburg, Virginia

23. FUNERAL DIRECTOR: E.H. B. Wolverton — ADDRESS: Funeral Home Inc 6306 Belair Rd, Baltimore 6, Md.
24a. REC'D BY REG STRAR: DATE DEC 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12148

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 99 Northwest Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 99 Northwest Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Evan — Last: Pointer (Bobby)

4. DATE OF DEATH: Month: November — Day: 27 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 25-1907

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Utilities
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Exp. Station

11. BIRTHPLACE (State or foreign country): Annapolis

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Pointer

14. MOTHER'S MAIDEN NAME: Agnes Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Velma B. Nash — Address: 808 Carrollton Ave. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: E. Lin Ladd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. Lin Ladd
DATE SIGNED: 11/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-1-60
22c. NAME OF CEMETERY OR CREMATORY: Pine Lawn
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 1 '60

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12149

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 5 Kirkley Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle William — Last Popow
4. DATE OF DEATH: Month 11 — Day 28 — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feby 10th 1914
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prof. of U.S. Naval Academy
10b. KIND OF BUSINESS OR INDUSTRY: TEACHER
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Popow
14. MOTHER'S MAIDEN NAME: Barbara Bohm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Helen Christine Popow (2) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): 434.4
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Elmer Landt, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 11/28/60
EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-1-1960
22c. NAME OF CEMETERY OR CREMATORY: Annapolis National
22d. LOCATION (City, town, or county) (State): Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: DEC 1 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VI AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150

12186

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Wilson Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
STREET ADDRESS (If rural give location) 19 Wilson Blvd.

3. NAME OF DECEASED (Type or Print) (First) Mc Rina (Middle) Estelle (Last) POWELL

4. DATE OF DEATH (Month) Nov (Day) 5 (Year) 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	WIDOW	Oct 9 1871	89 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Virginia	USA

13. FATHER'S NAME Joseph Ashburn
14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) —
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT & ADDRESS Mr Wm Powell, same as 7

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Cerebrovascular Oreident	one day
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerosis general	several years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1954, to Nov 5, 1960, that I last saw the deceased alive on Oct 25, 1960, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

SIGNATURE Joseph Taler, M.D. ADDRESS (Street, city, town, state) 102 Bd A Blvd. N.E. Glen Burnie, Md DATE SIGNED Nov 5, 60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 9, 1960	Rosedale Cemetery	Kilmarnock, Va.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
NOV 9 '60	Esther L. Travis	Hopping & Kirkley, Glen Burnie, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12187

CERTIFICATE OF DEATH

Reg. Dist. No. 12151

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 1 year 4 mo. 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Welcome, Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Welcome, Maryland
d. STREET ADDRESS: 07X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Sherman — Last: Proctor

4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/2/1934

9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): USA, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Jane Proctor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Inanition and Dehydration — 722.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ankylosing Rheumatoid Arthritis
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/26, 1959, to 11/10, 1960, that I last saw the deceased alive on 11/10, 1960, and that death occurred at 10 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Enrique J. del Campo, M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital — DATE SIGNED: 11-11-60

PHYSICIAN'S NAME (Type): Enrique J. del Campo — Crownsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11/14/60 — 22c. NAME OF CEMETERY OR CREMATORY: Zion Baptist — 22d. LOCATION (City, town, or county) (State): Hill Top, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Richard Funeral Home, La Plata, Md. — 24a. REC'D BY REGISTRAR DATE: NOV 21 '60 — 24b. REGISTRAR'S SIGNATURE: Clinton S. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12148

CERTIFICATE OF DEATH

12152

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 35 Cathedral St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 1st
d. STREET ADDRESS: 35 Cathedral St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Georgeana — Middle: — Last: Rawlings

4. DATE OF DEATH: Month: 11 — Day: 1 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-9-1909
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William McKinley Hosting
14. MOTHER'S MAIDEN NAME: Georgeana Lacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Sewell Rawlings 35 Cathedral St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: short time

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): metastases to bone organs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to 10-31-60 19___, that (I) (we) last saw the deceased alive on 10-30 1960 and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A T ALLEN
22d. ADDRESS: 61 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-4-1960
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hall
23d. LOCATION (City, town, or county): Annapolis (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Russell
ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

12149

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12153

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 78 College Ave Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
d. STREET ADDRESS: 78 College Ave Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle E. Last Reed

4. DATE OF DEATH: Month 11 Day 7 Year 1960

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-1898
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Mathews
14. MOTHER'S MAIDEN NAME: Susie Grass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Thomas Mathews 78 College Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

(a) Metastasis to Vital organs

DUE TO (b) Carcinoma / uterus — about 4 yrs

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) annapolis (County) a.a. (State) Md

21 I certify that (I) (this hospital) attended the deceased from 1-6-16 19 to 11-7-60 19 ; that (I) (we) last saw the deceased alive on 11-6-60 19 ; and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE: Chas T. Allen M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CHAS T ALLEN
22d. ADDRESS: 62 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-10-1960
23c. NAME OF CEMETERY OR CREMATORY: Bayview Hill
23d. LOCATION (City, town, or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Annapolis Md

25a. RECD BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12150 Item 8 Film 527b 12-2-60 et 12154

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Crownsville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Will — Middle: — Last: Robinson

4. DATE OF DEATH: Month: November — Day: 26, — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-2-1903

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Orangeburg S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-14-8604

17. INFORMANT: Geo. J. Carroll — Address: Crownsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Electrolyte Imbalance — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Vomiting & Diarrhea — 3 days
DUE TO (c): Cause undetermined.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: — a. m. p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-25-60 19___ to 11-26-60 19___, that (I) (we) last saw the deceased alive on November 26, 60 and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Aris T. Allen M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 8:35 A.M.

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. Aris T. Allen

22d. ADDRESS: Cathedral Street Annapolis, Md.

23a. BURIAL CREMATION REMOVAL (Specify): shipped

23b. DATE THEREOF: Nov. 26, 1960

23c. NAME OF CEMETERY OR CREMATORY: Emanuel

23d. LOCATION (City, town, or county) (State): Branchville S. C.

24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Johnson — ADDRESS: Annapolis

25a. REGD. BY REGISTRAR DATE: DEC 1 60

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12188

CERTIFICATE OF DEATH

Reg. Dist. No. 12155

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 626 N. Hammonds Ferry Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: Address
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martin — Middle: George — Last: Schneider

4. DATE OF DEATH: Month: Nov — Day: 5 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept 9, 1889

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Sales Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Antiques

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Schneider

14. MOTHER'S MAIDEN NAME: Elizabeth Herbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1st World

16. SOCIAL SECURITY NO.: 218-05-5487

17. INFORMANT: Christine Eichelman — Address: Sister (same)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10-12 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bronchial Asthma — 8-10 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 422

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 16, 1959 to Nov 5, 1960 that I last saw the deceased alive on Nov 5, 1960 and that death occurred at 6:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. M.D. — ADDRESS (Street, city or town, state): Linthicum Md. — DATE SIGNED: 11/2/60

PHYSICIAN'S NAME (Type): Charles L. Ball, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 11-8-60

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard J. Ruck 5305 Harford Rd.

24a. REC'D BY REGISTRAR — DATE: NOV 9 '60

24b. REGISTRAR'S SIGNATURE: Caitlin L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12151

CERTIFICATE OF DEATH

12156

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lottie; Middle: ; Last: SHERBERT

4. DATE OF DEATH: Month: November; Day: 14; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 14, 1881

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Stephen Suite

14. MOTHER'S MAIDEN NAME: Alma Suite

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wes Adm Carmore Address: Edgewater, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis generalized
DUE TO (b): Chronic myocarditis.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic pneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from Nov. 6, 19 60, to Nov. 14, 19 60 that (I) (We) last saw the deceased alive on Nov. 14, 1960, and that death occurred at 10:05 A.M., from the causes and on the date stated above

22a. SIGNATURE: C. E. Linhardt M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-17-60.

22c. PHYSICIAN'S NAME (Type): Elmer G. Linhardt

22d. ADDRESS: 3 Chesapeake Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov 17 1960

23c. NAME OF CEMETERY OR CREMATORY: Hope Chapel

23d. LOCATION (City, town, or county) (State): Edgewater Md

24. FUNERAL DIRECTOR'S SIGNATURE: T. A. Hardesty & Son ADDRESS: Galesville Md

25a. REC'D BY REGISTRAR DATE: NOV 21 '60

25b. REGISTRAR'S SIGNATURE: William S. Nevius

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12152

CERTIFICATE OF DEATH

12157

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 Dean Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 5 Dean Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELIZABETH — Last: SMITH

4. DATE OF DEATH: Month: November — Day: 23, — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 9, 1867

9. AGE (In years last birthday): 93 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Armen

14. MOTHER'S MAIDEN NAME: Frances McKelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17 INFORMANT — Address: Mrs. Catherine Smith 4604 Glenarm Ave.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Azotemia	4 days.
DUE TO (b)	Arteriosclerosis, Generalized	1 yr.
DUE TO (c)	Renal Insufficiency	2 wks.

450.0 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 6, 1960 to Nov 23, 1960 that (I) (we) last saw the deceased alive on Nov 18 1960, and that death occurred at 11:15 p.m., from the causes and on the date stated above

22a SIGNATURE: James R. Martin M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-23-60

22c. PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22d. ADDRESS: 6 SHAW ST. ANNAPOLIS, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11/26/60

23c NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

23d LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ullrich Funeral Home, 4210 Belair Road.

25a RECD BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12158

1. PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 52 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Oliver — Last: Snowden

4. DATE OF DEATH: Month: Nov. — Day: 10 — Year: 1960

5. SEX: M. — 6. COLOR OR RACE: C — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 8. DATE OF BIRTH: Feb. 3-1898 — 9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10b. KIND OF BUSINESS OR INDUSTRY: ********
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Snowden
14. MOTHER'S MAIDEN NAME: Rachel Wooten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-14-1498
INFORMANT: Floyd O. Snowden — Address: 120 South St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left Middle Lobe Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Old Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 6, 1960 to Nov 9, 1960, that I last saw the deceased alive on Nov 9, 1960, and that death occurred at 9:30 P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE: R.L. Richardson M.D.
PHYSICIAN'S NAME (Type): R.L.RICHARDSON — 110 Clay Street Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 13-60
22c NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 15 '60
24b REGISTRAR'S SIGNATURE: Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12189 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

18159

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 14 Brookfield Rd.

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: / Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Allison; Middle: Stallings; Last: Sr.

4. DATE OF DEATH: Month: November; Day: 24th; Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/8/21

9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab. Technician

10b. KIND OF BUSINESS OR INDUSTRY: Pasadena Md.

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clive Stallings

14. MOTHER'S MAIDEN NAME: Lillie Allison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): Yes

16. SOCIAL SECURITY NO.: 1-1-5552

17. INFORMANT: Mrs. Mary Stallings — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Partial Decapitation, by shooting himself with shotgun — INTERVAL BETWEEN ONSET AND DEATH: while

DUE TO (b): with a 12 gauge single barrell shot gun

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): As described in 1

20c. TIME OF INJURY: Hour a.m. p.m. 1:45 p.m. Month, Day, Year: 11/24/60

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): 14 Brookfield Rd. (County): Anne Arundel (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Paul, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/2/60

EXAMINER'S NAME (Type): Gustave H. Paul, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-3-60

22c. NAME OF CEMETERY OR CREMATORY: Magothy Church Cem.

22d. LOCATION (City, town, or country): Pasadena (State): Md.

23. FUNERAL DIRECTOR: Hopkins & Kirkley, Glen Burnie — ADDRESS:

24a. REC'D BY REGISTRAR DATE: DEC 6 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12190

CERTIFICATE OF DEATH

12160

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4mo. 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS: Route 1, Box 52
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilson — Middle: James — Last: Stewart

4. DATE OF DEATH: Month: 11 — Day: 28 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 3, 1888

9. AGE (In years last birthday): 72 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Stewart

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-30-5556

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): -------

20c. TIME OF INJURY: Hour: a. m. / p. m. ----- Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): -------

21. I **certify** that (I) (this hospital) attended the deceased from 7/7 19 60 to 11/28 19 60, that (I) (we) last saw the deceased alive on 11/28 19 60, and that death occurred at 2:40 P. M. from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D

ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 11/29/60

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-2-60

23c. NAME OF CEMETERY OR CREMATORY: Davidsonville

23d. LOCATION (City, town, or county) (State): Davidsonville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Allen Deale — ADDRESS: Edgewater Md.

25a. REC'D BY REGISTRAR: DATE DEC 2 '60

25b. REGISTRAR'S SIGNATURE: Arthur R. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

Item 20 Film 276 12-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12191

CERTIFICATE OF DEATH

12161

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville

c. LENGTH OF STAY IN 'b': 1 mo 3yrs 29 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

d. STREET ADDRESS: Unknown

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Clara; Middle: ; Last: Stovall

4 DATE OF DEATH: Month: 11; Day: 19; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: August 6, 1897

9. AGE (In years last birthday): 63 yrs

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS: Hours; Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Georgia Samuels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: ———

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inhalation of Food causing Suffocation
DUE TO
(b): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 1 min.
DUE TO
(c): Choked Food in Pharynx and Larynx N 933 — 1 Minute

921.7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(c) Chronic Brain Syndrome Associated with Central Nervous System Syphilis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Central Nervous System Syphilis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Accidental death with inhaled food particles after breakfast. Medical Examiner notified, but did not accept case.

20c. TIME OF INJURY Month, Day, Year: Hour a m p m 8 — 11 — 19 19 60

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town): Crownsville (County): A A (State): Md.

21 I certify that (I) (this hospital) attended the deceased from Sept. 20, 19 57 to Nov. 19 19 60 that (I) (we) last saw the deceased alive on Nov. 19 1960, and that death occurred at 9.20 A.M., from the causes and on the date stated above

22a. SIGNATURE: Hildegard Heard Reissman M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 11/21/60

22c PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.

22d ADDRESS: Crownsville State Hospital, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)

23b DATE THEREOF: 11/26/60

23c NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery

23d LOCATION (City, town, or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: A. Halstead

ADDRESS: 918 Druid Hill Ave

25a RECEIVED BY REGISTRAR DATE: 11 28 60

25b REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

Two for One: FilmG276 12-13-60 et

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12192 12162

CERTIFICATE OF DEATH

1. PLACE OF DEATH — a. COUNTY: Ann Arundel — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Ann Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — c. LENGTH OF STAY IN 1b: 4 yrs — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 109 Maple Ave. Glen Burnie — d. STREET ADDRESS: 109 Maple Ave. Glen Burnie — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: N. — Last: Suitt
4. DATE OF DEATH: Month: Nov. — Day: 24 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 12, 1924
9. AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months — Days —; IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Simone
14. MOTHER'S MAIDEN NAME: Catherine Contenti

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 039-09-5341
17. INFORMANT: Edward C. Suitt — Address: 109 Maple Ave. Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): Pulmonary Metastases — 3 mos
DUE TO (c): Adenocarcinoma Sigmaid Colon — 18 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that (I) (this hospital) attended the deceased from 7/10/19[illegible] 19[illegible] to 11/24, 1960, that (I) (we) last saw the deceased alive on 11/23 1960, and that death occurred at 6:15 P.M., from the causes and on the date stated above

22a. SIGNATURE: G. W. Richard — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): R. W. Richard
22d. ADDRESS: 71 Cotter Rd Glen Burnie Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/28/60
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem. Baltimore, Maryland
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard H. Hubbard 4107 Wilkens Avenue
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12154 12163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS: 52 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert — Middle: — Last: TATES
4. DATE OF DEATH: Month: November — Day: 15 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-9-1901
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): New Port News, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH: 4 mos

DUE TO (b): Chronic Alcoholism — 30 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~have attended~~ attended the deceased from Nov 15, 1960, to Nov. 15, 1960, that (I) ~~have~~ last saw the deceased alive on Nov. 15, 1960, and that death occurred at 8:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Theodore H. Johnson M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/16/60
22c. PHYSICIAN'S NAME (Type): Theodore H. Johnson
22d. ADDRESS: 37 Calvert St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-20-1960
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City, town, or county) (State): Annapolis, Md

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Ann., Md.
25a. RECD BY REGISTRAR DATE: NOV 17 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12155

CERTIFICATE OF DEATH

12164

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Churchton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sara — Middle: — Last: THOMPSON

4. DATE OF DEATH: Month: November — Day: 9 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 1, 1905
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Puckett
14. MOTHER'S MAIDEN NAME: Josephine Smith

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Porter Thompson Churchton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Essential hypertension — 4 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) attended the deceased from Nov. 4, 1960 to Nov. 8, 1960, that (I) last saw the deceased alive on Nov. 8, 1960 and that death occurred at 5:45 A.M. from the causes and on the date stated above

22a. SIGNATURE: Willard F Smith M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11/9/60
22c. PHYSICIAN'S NAME (Type): Willard F. Smith
22d. ADDRESS: Shadyside, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-13-1960
23c. NAME OF CEMETERY OR CREMATORY: St. Matthews
23d. LOCATION (City, town, or county): Shadyside (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese # ADDRESS: Annap. Md.
25a. REC'D BY REGISTRAR / DATE: NOV 10 '60
25b. REGISTRAR'S SIGNATURE: Conway J. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12193

CERTIFICATE OF DEATH

12165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 years 6mo. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2533 Woodbrook Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula — Middle: — Last: Torrence
4. DATE OF DEATH: Month: 11 — Day: 1 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1880
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia + Septicemia — INTERVAL BETWEEN ONSET AND DEATH

600.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Suppurative Nephritis

DUE TO (c): Purulent Cystitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): ------
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 ----
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State) ------

21. I **certify** that (I) (this hospital) attended the deceased from 1/12 19 56 to 11/1 19 60, that (I) (we) last saw the deceased alive on 11/1 19 60, and that death occurred at 2:05 A. M. from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M D
ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 11/1/60
22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/5/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
23d. LOCATION (City, town, or county) (State): Cedar Hill Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: E. O. Wilson 1002 Pratt Ave.
25a. RECD BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Klumb

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12194

CERTIFICATE OF DEATH

12166

Reg. Dist. No.

M

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION: District Training School Children's Center

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 104 - 15th Street N.E. Washington, D.C.
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5 11

3. NAME OF DECEASED (Type or print): First: Leo; Middle; Last: Van Look
4. DATE OF DEATH: Month: November; Day: 15; Year: 1960
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 6, 1898
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): unknown
12 CITIZEN OF WHAT COUNTRY?: ———

I

13. FATHER'S NAME: Edward M. Van Look
14. MOTHER'S MAIDEN NAME: Elizabeth P.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Address: Children's Center, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal pneumonia, dehydration, malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Epilepsy
DUE TO (c): Mental retardation

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): --
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that I attended the deceased from July 5th, 1960 to Nov. 15th, 1960, that I last saw the deceased alive on Nov. 14th, 1960, and that death occurred at 12:05 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: George T Economos M.D. ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. DATE SIGNED: 11/15/60

PHYSICIAN'S NAME (Type): George T. Economos, M.D. Children's Center, Laurel, Md. 11/15/60

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Nov 16, 1960
22c. NAME OF CEMETERY OR CREMATORY: District Training School
22d LOCATION (City, town, or county): Laurel (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John D Webster ADDRESS: District Training School
24a. REC'D BY REGISTRAR DATE: NOV 21 '60
24b. REGISTRAR'S SIGNATURE: Carlton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

X

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12195

12167

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): rural Riva
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Riva

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural Mayo
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle C. Last WARD

4. DATE OF DEATH: Month November Day 27 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 29, 1928

9. AGE (In years last birthday): 32 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): MAYO MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: WHEATLEY E. WARD SR.

14. MOTHER'S MAIDEN NAME: IVA MAE WITT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): Korean

16. SOCIAL SECURITY NO.:

17. INFORMANT: BEATRICE A. WARD Address: # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Traumatic Injuries — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Airplane Crash

20c. TIME OF INJURY Hour a.m. 1:00 Month, Day, Year Nov. 27 1960

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): field

20f. (City or town) Riva (County) Anne Arundel (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Petty

Address (Street, city, town, or county):

DATE SIGNED: 11/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-30-60

22c. NAME OF CEMETERY OR CREMATORY: MAYO MEM. CEM.

22d. LOCATION (City, town, or country): MAYO (State) MD.

23. FUNERAL DIRECTOR: JOHN M. TAYLOR · SON

ADDRESS: ANNAPOLIS

24a. REC'D BY REGISTRAR DATE NOV 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12196 **CERTIFICATE OF DEATH** 12168

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 years 1mo. 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laystonville
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elsie — Middle E. — Last Warfield

4. DATE OF DEATH: Month 11 — Day 24 — Year 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1887
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Dehydration and Inanition
DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardiovascular Renal Disease and Chronic Brain Syndrome Due to Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Hour o. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----
20f. (City or town) (County) (State): ----------

21 I certify that (I) (this hospital) attended the deceased from 6/13 19 23 to 11/24 19 60 that (I) (we) last saw the deceased alive on 11/24 19 60, and that death occurred at 9:45 A. M. from the causes and on the date stated above

22a SIGNATURE: Lionel McHenry Mapp M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 11/28/60
22c PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
22d ADDRESS: Crownsville State Hospital, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/30/60
23c. NAME OF CEMETERY OR CREMATORY: Brookside Grove
23d LOCATION (City, town, or county) (State): Laystonville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Saunders
ADDRESS: Rockville Md
25a. REC'D BY REGISTRAR DATE: DEC 5 '60
25b REGISTRAR'S SIGNATURE: Carlton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12158 (corrected) 12169

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: 43 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Odenton Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Odenton Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mae — Middle: Dodd — Last: Watts

4. DATE OF DEATH: Month: Nov. — Day: 13 — Year: 1960

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Mar 25, 1883

9 AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~XXXXXXX~~ Unknown Thomas Uhler

14. MOTHER'S MAIDEN NAME: ~~XXXXXXX~~ Clara Burgess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17 INFORMANT: Fulton Watts, Odenton, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March, 1955, to November, 1960, that (I) (we) last saw the deceased alive on 11-7-, 1960, and that death occurred at 2A M, from the causes and on the date stated above

22a SIGNATURE: Charles R. MacDonald M.D. M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c. PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.

22d ADDRESS: 204 Crain Hghy SW, Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11/16/60

23c NAME OF CEMETERY OR CREMATORY: Epiphany Church Cem.

23d. LOCATION (City, town, or county) (State): Odenton Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping and Kirkley

ADDRESS: Glen Burnie, Md.

25a REC'D BY REGISTRAR DATE: NOV 17 '60

25b REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12156

CERTIFICATE OF DEATH

12171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapplis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Riva
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herbert — Middle CARL — Last WICKSTROM

4. DATE OF DEATH: Month November — Day 29 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 16, 1899

9. AGE (In years last birthday): 61 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET N.Y. TEL Co

10b. KIND OF BUSINESS OR INDUSTRY: TELEPHONE

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: CHARLES L. WICKSTROM

14. MOTHER'S MAIDEN NAME: AUGUSTA LARSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Chester A. Wickstrom 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTRACTABLE CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 72 HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): HYPERTENSIVE CARDIOVASCULAR DISEASE — UNKNOWN
DUE TO (c): —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): BLEEDING DUODENAL ULCER

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that (I) ~~[illegible]~~ attended the deceased from 11-26, 1960, to 11-29, 1960, that (I) (we) last saw the deceased alive on 11-29, 1960, and that death occurred at 8:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck, M.D. — ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 11/29/60

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12-3-60

23c. NAME OF CEMETERY OR CREMATORY: FERNCLIFF CEMT.

23d. LOCATION (City, town, or county) (State): WHITE PLAINS N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: DEC 1 '60

25b. REGISTRAR'S SIGNATURE: Dillard S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12197

CERTIFICATE OF DEATH

12170

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY HA MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balt
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Hillcrest Ave.

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE Md. b. COUNTY H.H
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
d. STREET ADDRESS 211 Hillcrest Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Martha Middle E. Last Lee
4. DATE OF DEATH Month 11 Day 19 Year 60

5. SEX F
6 COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 10-30-73.
9. AGE (In years last birthday) 87 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ramos Miles
14. MOTHER'S MAIDEN NAME Rachael ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Family - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Chronic generalized Arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1955, to 11-19-60, that I last saw the deceased alive on 11/16/60, 19____ and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE Samuel Rubin M.D. ADDRESS (Street, city or town, state) 2031 Eutaw Place DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 11/23/60
22c NAME OF CEMETERY OR CREMATORY Mt Edwards
22d LOCATION (City, town, or county) Balto. (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE McCully ADDRESS 130 E Lort Ave.
24a. REC'D BY REGISTRAR DATE NOV 23 '60
24b. REGISTRAR'S SIGNATURE C. Wm S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12198

CERTIFICATE OF DEATH

12172

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade,
c. LENGTH OF STAY IN 1b: 4 mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Dunrovin Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STEPHEN — Middle L — Last WILCOX JR

4. DATE OF DEATH: Month NOVEMBER — Day 22 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 June 1925

9. AGE (In years last birthday): 35 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): Elmira, New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1947 to date

16. SOCIAL SECURITY NO: 129-16-2922

17. INFORMANT — Address: Personnel Records Ft Geo G. Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): blood loss

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 578 X

DUE TO (c): Upper gastro intestinal bleeding

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal shutdown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 18 Nov 1960 to 22 Nov 1960, that (I) (we) last saw the deceased alive on 22 Nov 1960, and that death occurred at 9:35 A.M. from the causes and on the date stated above.

22a SIGNATURE: Howard Bob Mass M.D

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 22 Nov 60

22c. PHYSICIAN'S NAME (Type): HOWARD BOB MASS, Capt., M.C.

22d ADDRESS: USA Hosp Ft Geo G, Meade, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)

23b DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

25a REC'D BY REGISTRAR DATE NOV 28 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12199

CERTIFICATE OF DEATH

12173 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 4405 Ritchie Hwy.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BALTO.
d. STREET ADDRESS: 4405 Ritchie Hwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle W. Last WOOD

4. DATE OF DEATH: Month 11 Day 15 Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-24-98
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U Pholsterer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John WOOD
14. MOTHER'S MAIDEN NAME: ANNIE [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-10-7331
INFORMANT: Family Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
DUE TO (b): Coronary Artery Disease — 1 year
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastric Ulcer - duration (?)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/12, 1960 to 11/15, 1960 that I last saw the deceased alive on 11/13, 1960, and that death occurred at 5 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Deibel M.D. ADDRESS (Street, city or town, state): 1226 Hanover St DATE SIGNED:
PHYSICIAN'S NAME (Type): DR. HARRY DEIBEL Balto 30 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 11-19-60
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.
22d. LOCATION (City, town, or county) (State): Glen Burnie, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Home ADDRESS: 130 E Fort Ave
24a. REC'D BY REGISTRAR DATE NOV 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12157

12174

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 28 Monroe Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ABE Middle FRANK Last ZELKOWITZ

4. DATE OF DEATH: Month November Day 3 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Prop.

10b. KIND OF BUSINESS OR INDUSTRY: Retail Grocery Store

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Zelkowitz

14. MOTHER'S MAIDEN NAME: Sarah Block

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mrs Goldie Zelkowitz- Wife- Same as # 2
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO
(b): Acute Coronary occlusion — 1 hr
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/3, 1960, to ____, 19____, that (I) (we) last saw the deceased alive on 11/3, 1960, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/3/60

22c. PHYSICIAN'S NAME (Type): RICHARD N. PEELER

22d. ADDRESS: ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 4, 1960
23c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery
23d. LOCATION (City, town, or county) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Hopping Funeral Home Annapolis, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Clothing L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59